

COPY



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. BUTCH OTTER, GOVERNOR
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

February 19, 2010

Brian Nall
Benewah Community Hospital
229 South 7th Street
Saint Maries, ID 83861

RE: Benewah Community Hospital, provider #131317

Dear Mr. Nall:

This is to advise you of the findings of the complaint survey at Benewah Community Hospital which was concluded on February 11, 2010.

Enclosed is a Statement of Deficiencies/Plan of Correction form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction.

An acceptable plan of correction (PoC) contains the following elements:

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the POC is effective in bringing the hospital into compliance, and that the hospital remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of the Form CMS-2567.

Brian Nall
February 19, 2010
Page 2 of 2


After you have completed your Plan of Correction, return the original to this office by **March 4, 2010**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office at (208) 334-6626.

Sincerely,



SUSAN COSTA
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/mlw

Enclosures

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131317	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/11/2010
NAME OF PROVIDER OR SUPPLIER BENEWAH COMMUNITY HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 229 SOUTH 7TH STREET SAINT MARIES, ID 83861		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
B 000	16.03.14 Initial Comments Surveyor: 28544 The following state deficiencies were cited during the complaint investigation of your facility. The following surveyors conducted the survey: Susan Costa, RN, HFS, Team Lead Patrick Hendrickson, RN, HFS Acronyms used in this report are as follows: CEO- Chief Executive Officer DON- Director of Nursing ED- Emergency Department IV- Intravenous RN- Registered Nurse	B 000	<p style="text-align: center;">RECEIVED</p> <p style="text-align: center;">MAR 08 2010</p> <p style="text-align: center;">FACILITY STANDARDS</p>	
BB458	16.03.14.470.05 Patient's Rights 05. Patient's Rights. Written Policies and procedures shall be developed regarding patient's rights. (10-14-88) a. Use of any form of physical restraint, forced treatment, chemical restraint or seclusion shall only occur in circumstances where there is established written policy and approved procedures to warrant such action and/ or is ordered by a physician; and (10-14-88) b. Each patient shall be allowed to communicate with persons outside the facility, except where excluded or limited in accordance with his comprehensive treatment plan. (10-14-88) c. Each patient shall be apprised of his rights. (10-14-88) This Rule is not met as evidenced by:	BB458		Benewah Community Hospital will revise the "Patient/Family Problem Solving" policy to include direct face-to-face communication, telephone communication, or written communication for final response to complainant. The policy revision will assure final communication with the complainant is done in a compassionate and appropriate manner. The policy & procedure will be revised as stated and presented to the Board of Trustees for review and approval. This process will be completed by 03/25/2010. Continued next page

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

Brian Nall

TITLE **CEO**

(X6) DATE

3/3/10

6699

ZV3P11

If continuation sheet 1 of 3

Bureau of Facility Standards

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BB458	<p>Continued From page 1</p> <p>Surveyor: 28544</p> <p>Based on record review, review of policy and procedures, and staff interviews, it was determined the facility failed to provide a written response to 3 of 8 patients (#1, #4, #7), who had filed grievances related to physician care in a 12 month period. This had the potential to result in a lack of clarity for complainants as to the steps taken to resolve the grievances and the resolution of the grievances. Findings include:</p> <p>The hospital's policy titled "<u>Patient/Family Problem Solving</u>" dated 9/2002 and revised 11/2008, stated, "The time frame for a response to the patient/family will be within a week of the cited problem." The policy further stated a written notice would be sent to the patient/family upon completion of the problem review.</p> <p>This policy was not followed as evidenced by the following examples:</p> <ol style="list-style-type: none"> 1. Patient #1 was a 56 year old female who had 15 admissions to the ED between May 2008 and July 2009. <p>In an interview with the CEO on 2/12/10 at 10:30 AM, he provided documentation of meetings and phone contact he had with Patient #1 as follows:</p> <ol style="list-style-type: none"> a. 6/05/07 a meeting with Patient #1. b. 7/01/08 a phone call to request a meeting to discuss Patient #1's previous 3 ED visits. c. 7/08/08 a meeting after an ED visit. d. 7/17/08 meeting to discuss concerns and set up a meeting with the Medical Director. e. Patient #1 met with the Medical Director, who is also the ED director. <p>The CEO stated during the same interview that</p>	BB458	<p>To assure continued monitoring and tracking, both the date and the method of final communication have been added to the patient complaint tracking log.</p> <p>Nancy Moss, RN, Performance Improvement/Risk Manager will be responsible for implementing this plan of correction.</p>	3/25/10

Bureau of Facility Standards

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BB458	<p>Continued From page 2</p> <p>no letter of response was sent to Patient #1 after the above meetings.</p> <p>2. Patient #7 was seen in the ED on 9/28/09. She came in the following day and spoke with the CEO regarding a complaint about the treatment provided by a physician. According to the complaint log entry, Patient #7 stated the physician had made "snide" comments and she felt the physician had devalued her because he did not show concern for her well being.</p> <p>In an interview with the CEO on 2/11/10 at 10:30 AM, he stated he tried to call the patient on 11/2/09, but the telephone was no longer in service. He stated there was no written response sent to the patient.</p> <p>3. Patient #4 was seen in the ED on 10/06/08 and his wife had sent in a complaint which was received on 10/07/08 listing concerns with how his wound was managed. The complaint log entry listed physician as well as nursing concerns.</p> <p>In an interview with the CEO on 2/11/10 at 2:00 PM, he stated the record of Patient #4 was reviewed by the Medical Director, but no letter of response was sent to the patient.</p> <p>The facility failed to follow up in writing to respond to grievances filed by patients.</p>	BB458			



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February 22, 2010

Brian Nall
Benewah Community Hospital
229 South 7th Street
Saint Maries, ID 83861

Provider #131317

Dear Mr. Nall:

On **February 11, 2010**, a complaint survey was conducted at Benewah Community Hospital. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00003965

Allegation #1: Hospital did not respond to complaints regarding Emergency Department physicians' insensitive and poor bedside manner.

Findings: Clinical records, facility policy and procedures, grievance logs were reviewed, and staff interviews were conducted.

Review of the grievance log documented 3 patients who had concerns about the physicians' "lack of compassion" when they had been seen at the facility.

A policy titled "Patient/Family Problem Solving," dated 9/02 and revised 11/08, stated: "The time frame for a response to the patient/family will be within a week of the cited problem." The policy further stated a written notice would be sent to the patient/family upon completion of the problem review.

One patient who had filed a grievance was a female with 15 admissions to the Emergency Department in the 12 month period of review.

In an interview with the Chief Executive Officer on 2/11/10 at 10:30 AM, he provided documentation of 3 meetings and 2 phone contacts he had with the patient.

The CEO stated there was no letter of response sent to the patient after the above meetings.

Another patient was seen in the Emergency Department on 9/28/09 and spoke with the Chief Executive Officer on 9/30/09 regarding complaints of unsatisfactory treatment provided by a physician.

In an interview with the Chief Executive Officer on 2/11/10 at 10:30 AM, he stated he tried to contact the patient on 11/02/09, but the telephone was no longer in service. He stated there was no written response sent to the patient.

A third patient was seen in the Emergency Department on 10/06/08 and a complaint was received on 10/07/08 listing concerns with how a wound was managed.

In an interview on 2/11/10 at 2:00 PM with the Chief Executive Officer, he stated the record was reviewed by the Medical Director of the Emergency Department, but no letter of response was sent.

In an interview on 2/11/10 at 10:05 AM, the Medical Director of the Emergency Department stated the medical care provided by the physicians was appropriate, but sometimes they are "direct" with patients and less tactful than what some patients wanted. The Medical Director had provided 2 physicians with an article he had received from the Chief Executive Officer, titled "The power of the why behind the what." He stated he had asked the physicians to read the article. He further stated the physicians were under contract, and complaints regarding physicians were reviewed by the Morbidity and Mortality Committee as well as himself. He stated that complaints will be considered at the time of review for recredentialing.

The facility failed to ensure that all grievances were responded to in an appropriate, consistent manner. The facility failed to respond in writing to 3 of 8 patients who had filed grievances as per policy. A deficiency was cited at 16.03.14.470.05 (Patient Rights), under state licensing rules for hospitals in Idaho.

Conclusion: Substantiated. State deficiencies related to the allegation are cited.

Allegation #2: Emergency Department physicians were inadequately treating patient medical needs and sent patients home without treatment for nausea, vomiting and dehydration.

Findings: Clinical records, facility policy and procedures, and staff interviews were conducted. Twenty-three records of patients who had been seen in the Emergency Department were reviewed.

One record reviewed was that a 56 year-old female that had been to the Emergency Department 7 times in a 12 month period for nausea, vomiting or abdominal pain. The treatments provided were consistent; all included intravenous fluids and pain medications. Lab tests were ordered which included CBC, CMP, amylase, and lipase. None of the Emergency Department visits resulted in an admission to the facility. Review of the records showed Emergency Department visits resulted in a resolution of the symptoms before being discharged home, which ranged from 2 hours to 6 hours from time of arrival to the Emergency Department. There was evidence of discharge instructions in each record that had been signed by the patient, which included information to follow up with the care provider.

In an interview, on 1/11/10 at 10:05 AM, the Medical Director of the Emergency Department reviewed the records and stated the patient had been discharged after appropriate treatment for dehydration and review of the lab work.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: Emergency Department patients had extended waiting periods before being seen by a physician.

Findings: Clinical records, facility policy and procedure, and staff interviews were conducted. Twenty-three Emergency Department records of visits in a 12 month period were reviewed, with wait times of ranging from <1 minute to 19 minutes from the arrival of the patient in the Emergency Department until the physician was at the patient's bedside.

In an interview with the Medical Director of the Emergency Department on 2/11/10 beginning at 10:05 AM, he stated the facility hired the Emergency Department physicians to cover the Emergency Department on a 24 hours a day, 7 days a week basis, and the physician had no other clinic or floor obligations during the scheduled hours in the Emergency Department. He further stated that patient wait time was related to the activity in the Emergency Department and the triage process.

It could not be determined that Emergency Department patients had extended wait periods before being seen by the physicians. No deficiencies were cited.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: Emergency Department physicians wrote sarcastic notes in patients' records.

Findings: Clinical records, facility policy and procedures, and staff interviews were conducted.

Twenty-three records of patients who had been seen in the Emergency Department during 2008 and 2009 were reviewed. There was no evidence of sarcasm or inappropriate verbage in the records reviewed.

It could not be determined that there were sarcastic remarks written in the Emergency Department records reviewed. No deficiencies were cited.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #5: Nursing staff used water to cleanse the skin prior to IV insertion.

Findings: Clinical records, facility policy and procedures, and staff interviews were conducted.

In an interview on 2/11/10 at 1:40 PM with the facility Director of Nursing, she provided a copy of the policy for IV catheter placement. The Director of Nursing also stated the facility utilizes "Potter and Perry" for nursing procedural resources.

In an interview with the Assistant Director of Nursing on 2/11/10 at 2:45 PM, she explained the procedure of an IV or lab venipuncture. She explained the facility used a prepackaged kit, which included a chloroprep ampule, to cleanse the skin prior to venipuncture. The Assistant Director of Nursing stated the facility used alcohol for skin cleansing until about 2 years ago, when they switched over to the chloroprep kits. When questioned about allergies and if water was ever used for skin cleansing; she responded that she had never used water, and that she would use betadine, alcohol, or chloroprep as the only products.

It could not be determined that water was used to cleanse skin prior to IV insertion. No deficiencies were cited.

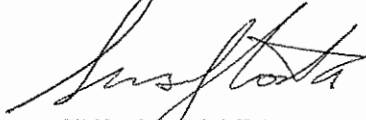
Conclusion: Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it was addressed in the Plan of Correction.

Brian Nall
February 22, 2010
Page 5 of 5

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,



SUSAN COSTA
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/mlw